Outpatient Physical, Occupational, and Speech Therapy
Questions and Answers

Pre-certification Requirements

1. **Why did DOM implement pre-certification requirements for outpatient physical, occupational, and speech therapy services?**

   The decision to pre-certify outpatient therapy services is in keeping with the Division of Medicaid's responsibility to be a prudent purchaser of high quality health care and to ensure that benefits are provided for medically necessary services. DOM implemented the pre-certification process on July 1, 2005. On February 1, 2006, DOM further enhanced the process with policies and standardized forms. DOM's review of the process resulted in the July 1, 2006, revisions to the forms and some policy sections.

2. **What is the role of HealthSystems (HSM) of Mississippi?**

   HealthSystems of Mississippi is the Utilization Management and Quality Improvement Organization (UM/QIO) for the DOM. HSM's scope of responsibility includes the management of the pre-certification process for outpatient therapy services. In addition, HSM handles a process for addressing quality of care issues on therapy services.

3. **Does DOM require pre-certification for all therapy codes billed by a hospital or therapy provider?**

   No. There is a list of specific therapy codes for which DOM requires pre-certification. That list may be accessed on the UM/QIO web site, www.hsom.org. Click on the HSM Provider Manual and Certification Forms link, and then select "Outpatient Physical, Occupational, and Speech Therapy Provider Manual and Certification Forms".

4. **Can a provider bill for a therapy code not on the attached list if the service is covered under Mississippi Medicaid?**

   Yes

5. **If the number of approved units for a period of time is not used, can the therapy provider carry over the unused units to another time period?**

   No. Units cannot be carried over from one period of time to another. The provider must submit a concurrent request if additional therapy is required. Providers are encouraged to document reasons previous approved units have not been utilized. For example, if a child is ill and is unable to participate in therapy for a week, the therapist should document this as it is information that HSM needs to make determinations for further coverage.

6. **How do I handle urgent situations?**

   HSM is authorized to accept retrospective outpatient therapy requests for the following:

Urgent Services: In rare instances where urgent services are provided, the provider must follow the UM/QIO guidelines for submitting urgent certification requests. Urgent outpatient physical, occupational, or speech therapy services is defined as the delivery of therapy services resulting from the sudden onset of a medical condition or injury requiring immediate care and manifesting itself by acute symptoms of sufficient severity such that the absence of therapy could result in immediate hospitalization, moderate impairment to bodily function, serious dysfunction of a bodily organ or part, or other serious medical consequences. If retrospective review reveals that the services do not meet medical necessity criteria, charges will not be reimbursed and cannot be billed to the beneficiary.

Same Day/Non-Urgent Services: In rare instances where same day/non-urgent services are provided, the provider must follow the UM/QIO guidelines for submitting urgent certification requests. Same day/ non-urgent outpatient physical, occupational, or speech therapy services is defined as the delivery of therapy services that do not meet the definition of urgent, but completion of services on the same day as the evaluation significantly impacts the beneficiary's treatment (example: therapeutic activities, such as the use of crutches, on the same day as diagnosis/treatment of leg fracture). If retrospective review reveals that the services do not meet medical necessity criteria, charges will not be reimbursed and cannot be billed to the beneficiary.

Refer to DOM Provider Policy Manual Sections 47.09, 48.09, and 49.09.

Standardized Form Requirements

1. **Why is the Division of Medicaid requiring that prescribing providers and therapists utilize the standardized forms to submit pre-certification requests to HSM?**

   DOM made the decision to develop and require use of the standardized forms to (1) ensure consistency in reporting, (2) to respond to provider requests to define the information needed for the pre-certification request, (3) to assist in provider education, and (4) to expedite review processes at HSM. The development of the forms was a joint effort between DOM and HSM with input from therapists working with HSM.

   DOM recognizes that the requirement adds additional paperwork; however, it is necessary in order to obtain complete medical information for the review process.

2. **Does DOM / HSM plan to develop an electronic process for submitting the requests?**

   Yes. Electronic submission is a long term goal. Electronic submissions have been successful for pre-certification of inpatient days and home health visits. It is anticipated that this technology can be adapted for pre-certification of therapy services. Currently, providers may access manual or electronic forms through the HSM website (www.hsom.org). The electronic form may be saved to the user's computer. It is a fill-able form, but it may not be submitted electronically to HSM at this time.

3. **May providers attach documents and write "see attachments" on the standardized forms?**

   Providers must complete the standardized forms. An addendum page has been added to allow extra space for provider documentation. If the provider utilizes the space on the forms and addendum page, and still needs to continue, the provider may write "see attachment" and add the additional information. The provider may not add attachments in lieu of completing the forms.

Prescribing Provider

1. **What is the role of the prescribing provider (physician, nurse practitioner, physician assistant)?**

   The policies and processes are designed to reflect the traditional role of the prescribing provider's authority and responsibility to direct the care of his/her patients. To maintain the patient-prescribing provider relationship, and to ensure that medically necessary therapy continues to be assessed for effectiveness and quality, the pre-certification policies and processes call for prescribing providers to participate at several levels. This includes the (1) completion of the Certificate of Medical Necessity as the initial referral/orders, (2) approval of the initial and all revised plans of care and (4) a face to face visit with the beneficiary at least every six months. Such oversight and visits give the prescribing provider the opportunity to assess the beneficiary's progress toward therapeutic goals and to either authorize continued therapy or to discharge the beneficiary from therapy. Refer to DOM Provider Policy Manual Sections 47.10, 48.10, and 49.10.

2. **Is DOM/HSM educating providers about their responsibilities?**

   Yes. HSM has conducted an education program with many of the prescribing therapy providers.

3. **How often must a beneficiary be physically seen by the prescribing provider?**

   DOM policy requires that the prescribing provider have a face-to-face visit with the beneficiary at least every six (6) months, and that the encounter be documented. Refer to DOM Provider Policy Manual Sections 47.10, 48.10, and 49.10.

Certificate of Medical Necessity (CMN)

1. **What is the purpose of the Certificate of Medical Necessity (CMN)?**

   The CMN form is the prescribing provider's initial referral/orders. This requirement is consistent with the prescribing provider's authority and responsibility to direct care of his/her patients. The use of the standardized form provides consistency.

2. **Does the CMN form replace the prescribing provider's prescription?**

   Yes. The CMN is accepted as the prescribing provider's prescription for therapy.

3. **Will the Division of Medicaid policy allow a prescription in lieu of the CMN?**

   No

4. **Will the Division of Medicaid policy allow a verbal order in lieu of the CMN?**

   No

5. **Does the CMN have to be completed by the prescribing provider? Will the Division of Medicaid policy allow a prescribing provider to dictate the information and order to an office, staff member, or therapy provider (that is, give a verbal order that includes the required information on the CMN)?**

   It is acceptable for a **member of the prescribing provider's staff** to complete the beneficiary and provider information and diagnoses **only**. The prescribing provider must validate the accuracy of the information and complete the remainder of the form, including the specific order(s). The prescribing provider must sign and date the form. A verbal order is not acceptable.

6. **Does the CMN form have to be completed before the therapist conducts the initial evaluation?**

   Yes. Refer to Sections 47.10, 48.10, and 49.10 of the DOM Provider Policy Manual.

Evaluation/Reevaluation

1. **Who performs the evaluation and completes the evaluation form?**

   The evaluation must be completed by a state licensed therapist of the same discipline as the requested therapy (example: physical therapist must perform the evaluation for physical therapy). Refer to Sections 47.11, 48.11, and 49.11 of the DOM Provider Policy Manual.

2. **The Division of Medicaid provides coverage for re-evaluations based on medical necessity. Please clarify this policy.**

   It is expected that re-evaluations happen frequently throughout the process of providing the therapy. These routine re-evaluations are part of providing therapy services and are not eligible for separate reimbursement. Re-evaluations which may be considered for medical necessity include instances where there is significant change in the beneficiary's condition or functional status. Refer to Sections 47.11, 48.11, and 49.11 of the DOM Provider Policy Manual.

   DOM has also provided HSM with authorization to consider re-evaluations in instances where the beneficiary is being followed by a physician specializing in rehabilitation and the physician requests further evaluation by another therapist to assist in evaluating further therapy needs for the beneficiary. In this type instance, it is expected that the beneficiary is receiving therapy in his/her local community, and it is recognized that the therapist providing the therapy will also be doing re-evaluations.

3. **Can the therapist evaluate and initiate treatment on the same day?**

   The initial evaluation and the first therapy session should not be done on the same day. The provider should allow time to develop a plan of care and to obtain certification from the UM/QIO. Refer to Sections 47.11, 48.11, and 49.11 of the DOM Provider Policy Manual.

   Policy does include a provision for handling **urgent** cases. Refer to Sections 47.09, 48.09, and 49.09 of the DOM Provider Policy Manual.

Plan of Care (POC)

1. **Does the Plan of Care (POC) have to be developed for a specific period of time?**

   The POC may be developed to cover a period of treatment up to six months. The projected period of treatment must be indicated on the initial POC and must be updated with each subsequent revised POC. A POC for a projected period of treatment beyond six (6) months is not acceptable.

   The projected period of treatment indicated on the POC does not guarantee approval by the UM/QIO. Based on medical necessity, the UM/QIO may approve certification periods for less than **OR** up to six (6) months. Approved certification periods will not exceed the period of treatment indicated on the POC. Refer to Sections 47.12, 48.12, and 49.12 of the DOM Provider Policy Manual.

2. **Is the prescribing provider required to complete the plan of care form? When does it have to be signed?**

   Therapy services must be furnished according to a written plan of care (POC). The plan of care must be **approved** by the prescribing provider **before** treatment is begun. "Approved" means that the prescribing provider has reviewed and agreed with the therapy plan. The review can be done in person, by telephone, or facsimile. An approved plan does not mean that the prescribing provider has signed the plan prior to implementation, only that he/she has agreed to it. The plan of care must be developed by a therapist in the discipline. The prescribing provider must sign the POC before the initiation of treatment **OR** within thirty (30) calendar days of the verbal order approving the treatment plan. Policy does include a provision for handling urgent cases. Refer to DOM Provider Policy Manual Sections 47.12, 48.12, and 49.12.

3. **When does DOM require a revised POC?**

   A revised POC is necessary any time one of the following occurs:

   - The projected period of treatment is complete and additional services are required.

   - A significant change in the beneficiary's condition and the proposed treatment plan requires that (1) a therapy provider propose a revised POC to the prescribing provider, or (2) the prescribing provider requests a revision to the POC. In either

case, the therapy provider must submit a revised POC to the UM/QIO for certification prior to rendering services.

- Information/documentation submitted to the UM/QIO indicates that the POC needs further review/revision by the therapist/prescribing provider at intervals different from the proposed treatment dates. In this situation, the UM/QIO is authorized by DOM to request that the therapy provider submit a revised POC. The therapy provider must submit a revised POC to the UM/QIO for certification prior to rendering services.

All therapy plans of care (initial and revised) must be authenticated (signed and dated) by the prescribing provider. The prescribing provider must sign the POC before initiation of treatment **OR** within thirty (30) calendar days of the verbal order approving the treatment plan. This applies to both initial and revised plans of care.

DOM accepts the signature on the revised plan of care as a new order.

Refer to DOM Provider Policy Manual Sections 47.12, 48.12, and 49.12.

Review Process

1. **Who reviews the pre-certification requests?**

   The review process is handled through the Utilization Management and Quality Improvement Organization, HealthSystems of Mississippi, based on information provided by the prescribing providers and therapists, medical necessity criteria, and Division of Medicaid policies.

2. **What criteria are used for medical necessity?**

   DOM has authorized use of the Milliman *Care Guidelines* as a tool to be used in review of the medical necessity. The *Care Guidelines* are evidence-based tools that reflect current best practices for the actual working environment of today's healthcare organizations.

3. **Are the Milliman *Care Guidelines* applicable to only adults?**

   No. The *Care Guidelines* are not specific to adults only. Each review for children is carefully and individually evaluated in accordance with standards and the growth and development process for children. Both DOM and HSM are focused on ensuring children do receive medically necessary services.

4. **Are Milliman *Care Guidelines* available to providers?**

   DOM and HSM do not provide copies of the Milliman *Care Guidelines* to providers. The guidelines are a commercially available product through www.milliman.com.

5. Is HSM authorized to reduce frequency and length of services without getting the prescribing provider's approval?

Yes. This is consistent with the role of utilization management companies who are contracted to approve services based on documented medical necessity and application of criteria and policies for the payor source.

6. What are the timelines for HSM providing a response to a request?

For pre-certification and concurrent requests, HSM will complete the review within 3 business days of receipt of all necessary information. For example, if a pre-cert/concurrent request is received on Monday, the provider will have a response by close of business Wednesday.

For retrospective requests, HSM will complete the review within 20 business days of receipt of all necessary information. For example, if a retrospective request is received on April 3, 2006, the provider will have a response by close of business May 3, 2006.

If a pre-certification request is pended for additional administrative information (clerical level) or additional clinical information (nurse level), the provider has three (3) business days to submit the information. The receipt date of the request is updated when the information is received.

If a concurrent request is pended for additional administrative information (clerical level), the provider has three (3) business days to submit the information. If a concurrent request is pended for additional clinical information (nurse level), the provider has one (1) business day to submit the information. The receipt date of the request is updated when the information is received.

If a pre-certification /concurrent request is pended by the physician review team, the provider has one (1) business day to submit the information. The receipt date of the request is updated when the information is received.

If a retrospective request is pended for additional information (nurse level), the provider has ten (10) business days to submit the information. The receipt date of the request is updated when the information is received. If a review is pended at multiple levels, such as clerical, nurse, physician, the timeframe is extended accordingly.

7. How does HSM determine the start date for therapy services?

The start date for **initial** certification of therapy services (excluding the evaluation) is three (3) days from the receipt of all necessary information for a review request. The start date for certification of a **concurrent** review request is the date following the last certified day if the request is received in a timely manner (example: If the first certification period is 7/1/06 through 7/31/06, the concurrent certification period will begin 8/1/06 if the concurrent review request is submitted on or before the last day certified).

8. **Does HSM certify therapy services for beneficiaries who have <u>private</u> insurance as primary?**

   If the beneficiary has both Medicaid and private insurance and the provider plans to bill Medicaid, the therapy treatment must be pre-certified by HSM.

9. **Can I appeal HSM's decision?**

   DOM has contracted with HSM to handle reconsideration requests based on denial of services. All appeals other than those based on denials must be appealed directly to DOM.

Electronic Documentation / Electronic Signatures

1. **Will DOM allow hospitals to submit electronic documentation/signatures in lieu of the standardized forms?**

   Some hospital providers have expressed interest in adapting the standardized therapy forms into their own electronic documentation. If a hospital provider wants to explore this option, the hospital provider must submit a proposal in writing to HSM. DOM and HSM will review the proposal and determine if electronic documentation is acceptable in lieu of the standardized forms. DOM will expect the electronic formats to duplicate the standardized forms.

Home Exercise Program (HEP)

1. **What does HSM expect the provider to document for HEP?**

   The provider should describe the home program and the frequency that it is performed. The responsible caregiver should be identified and his/her response documented (example: ability to perform return demonstration and verbalization of understanding of the HEP). Frequency that the HEP is performed by the caregiver should be documented on concurrent requests. If applicable, the reason(s) that a caregiver is unable to participate in the HEP should be documented.

2. **Will HSM accept 'not applicable" for the HEP (example: beneficiary with autism-family needs keys for management, not HEP)?**

   No, HSM will not accept "NA" for the HEP. For HSM's purposes, HEP is defined as anything that the caregiver or beneficiary is doing on a daily basis to reinforce the goals and skills learned in therapy.

3. **What is expected of families or caregivers?**

   A home program is included in a successful therapy plan of care. DOM expects prescribing providers and therapists to include home programs for families and caregivers. It is further expected that the families and caregivers be available for instruction/training by

the therapist and participate in and be compliant with the home programs to ensure that the beneficiary is able to achieve and maintain the maximum level of function.

Maintenance Policy

1. **Does DOM policy provide coverage for therapy for maintenance?**

   No. Refer to DOM Policy Provider Manual Sections 47.13, 48.13, and 49.13.

Services in Multiple Settings

1. **Does the DOM policy allow coverage if the beneficiary is being seen for the same therapy service in multiple settings? An example is a child receiving speech therapy services at school and at a therapy clinic.**

   No.

Hospitals Off-Site Therapy Services

1. **Can a hospital provide a therapy service by salaried/contracted therapists at an off – site location and bill DOM for the service?**

   Hospitals are expected to bill only for services provided in a hospital outpatient therapy facility. Providing services outside of the facility is not considered an outpatient hospital service (example: beneficiary home, daycare, or school).

   Facilities may be on or off the hospital's main campus but within the service area of the hospital. A broad example is that DOM does not accept a hospital in North Mississippi setting up an outpatient hospital facility in central or south Mississippi.

Contact for Beneficiary Inquiries

1. **Who can adult beneficiaries or parents/legal guardians for children contact if they have questions or complaints?**

   Providers must direct adult beneficiaries or parents/legal guardians for children to the DOM's Beneficiary Relations Division at telephone (601) 359 – 6133. HSM is only authorized by DOM to handle provider inquiries.

   The DOM's Beneficiary Relations Division will only communicate with adult beneficiaries or parents/legal guardians of children due to the privacy regulations.

   In addition, parents/legal guardians may submit written inquiries to the Beneficiary Relations Division, Division of Medicaid, Robert E. Lee Bldg. / Suite 801, 239 North Lamar Street, Jackson, MS 39201-1399.

Claims Filing / Payment Issues

1. **Why are hospitals having difficulty getting claims paid for approved therapy services?**

   Systems issues that originally caused outpatient hospital claims to deny have been corrected. If hospital claims are not paying correctly, please contact your provider representative or the Division of Medicaid, Bureau of Medical Services.

   Some common reasons that outpatient therapy claims deny include the following:

   - Procedure codes billed do not match the procedure codes listed on the prior authorization
   - Dates of service on the claim do not match the dates listed on the prior authorization
   - Units billed exceed the units approved on the prior authorization
   - No prior authorization number (TAN) was listed on the claim
   - The prior authorization number (TAN) listed on the claim was not valid

2. **Who does a provider contact about questions on coverage of codes that do not require pre-certification?**

   The provider may contact the ACS Call Center at 1-800-884-3222 or their respective provider representative.

3. **Do the outpatient therapy visits apply toward the service limits?**

   No, except when the beneficiary has an emergency room visit on the same day.

Resources

1. **How does a prescribing provider or a therapy provider access the DOM policies?**

   DOM policies may be accessed at www.dom.state.ms.us. The therapy policies are in Sections 47 (physical therapy), 48 (occupational therapy), and 49 (speech therapy) of the DOM Provider Policy Manual.

2. **How does a provider access the HSM provider manuals and standardized forms?**

   A provider may access the HSM provider manuals at www.hsom.org. Click on the HSM Provider Manual and Certification Forms link, and then select "Outpatient Physical, Occupational, and Speech Therapy Provider Manual and Certification Forms".

3. **How does HSM provide training to the therapy providers in the pre-certification process?**

   Educational training sessions were offered to therapy providers during the past year. Providers who were unable to attend previous sessions and/or who desire further training may call the HSM Education Department at (601) 360-4961.

4. How does a provider contact the HSM Help Line?

The toll free number is (866) 740-2221. The number for the Jackson area is (601) 360-4949.